Employee Insurance Program
Incapacitated Child Certification Form

This information is required to verify incapacity for an eligible dependent child. Incapacity must be established before age 19 or while a covered and eligible full-time dependent student (within 31 days of loss of full-time student status).

- **Please attach a withdrawal letter from the educational institution the child was attending, so we can verify eligibility at the time of incapacitation.**
- **Please attach a completed Authorized Representative Form, signed by the incapacitated child, or other documentation that verifies your authority to act on behalf of the child (e.g., guardianship papers or power of attorney).**

SECTION A (*subscriber completes this section*)

Subscriber's Name:	Subscriber's BIN or SSN:
Phone Number:	❑ Active Employee ❑ COBRA ❑ Retiree ❑ Survivor
Address:	Dependent's Name: Dependent's Date of Birth: Dependent's SSN:

Is this dependent covered by any other health benefits, including Medicare/Medicaid? ❑ No ❑ Yes If *Yes*, give the name of the other insurance carrier:_____
Effective date of other coverage:_____
Policy number of other coverage:_____
Has dependent applied for Social Security Income? ❑ No ❑ Yes If *Yes*, give date:_____

When did this incapacitation begin?_____

Is the dependent married? ❑ No ❑ Yes Has the dependent ever been married? ❑ No ❑ Yes
Is the dependent living at home? ❑ No ❑ Yes If *No*, where does the dependent reside?_____

Are you, the subscriber, more than 50% financially responsible for the dependent? ___No ___Yes **If *Yes*, please attach a copy of your latest tax return or other supporting financial documentation.**

Is the dependent employed? ❑ No ❑ Yes If *Yes*:
Place of employment:_____ Number of hours worked weekly: _____
Job description:_____

Has the dependent ever been employed? ❑ No ❑ Yes If *Yes*:
Time period of last employment:_____
Place of employment:_____ Number of hours worked weekly: _____
Job description:_____

I hereby certify that, to the best of my knowledge, all information provided is correct and that this dependent is incapable of full-time student status and self support and remains dependent on me for support and maintenance. I understand that it is my responsibility to notify the Employee Insurance Program (EIP) within 31 days of any change in this dependent's eligibility and that Standard Insurance Company and EIP may review the status as necessary to verify continued eligibility. I acknowledge that failure to notify EIP of changes in eligibility may result in penalties and recovery of benefits paid on behalf of the ineligible dependent.

_____ _____
Subscriber's Signature Date

I hereby authorize Standard Insurance Company and EIP personnel to contact healthcare providers, to request claims history and to confirm student-status history while determining this dependent's incapacity and eligibility for benefits. I also understand that I may be required to provide more information for determining this dependent's incapacity. I also understand that all information provided will be considered in determining this dependent's incapacity.

_____ _____
Subscriber's Signature Date

If you have any questions, please call us at 803-734-0678 or toll-free at 888-260-9430.

Return this completed form and attached documents to the Employee Insurance Program, PO Box 11661, Columbia, SC 29211.

Employee Insurance Program

Incapacitated Child Certification Form

SECTION B (*dependent's physician must complete all areas of this section*)

Dependent's Name:	Dependent's SSN:
Date incapacity began:	Date you last examined this individual:

Diagnosis and description of the incapacitation: _____

Current treatment frequency and description: _____

Additional services or coordination of care: _____

Is the dependent institutionalized? ❑ No ❑ Yes If *Yes*, give the name of the institution: _____

Dates of confinement: _____

Nature of care: _____

If the diagnosis is psychiatric, please complete the following:

Complete DSMTV diagnosis required with descriptors, codes and severity specifiers:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: current: _____ highest in the last year: _____

Is the dependent fully compliant with treatment? ❑ No ❑ Yes

If *No*, would the prognosis be different if the dependent were compliant? _____

Has the dependent been hospitalized for a psychiatric condition? ❑ No ❑ Yes

If *Yes*, give the date and facility: _____

What is the nature and degree of the dependent's impairment in relation to the capacities for:

Daily activities: _____

Task performances: _____

Social interaction: _____

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Please return this completed section to the subscriber who gave it to you.

Employee Insurance Program

Incapacitated Child Certification Form

SECTION B (continued)

Dependent's Name:	Dependent's SSN:

In your professional opinion do you consider this individual to be *permanently and totally incapacitated* and incapable of full-time student status and incapable of self-support (e.g., based on your diagnosis, will the individual always be dependent on someone else for support and maintenance and never capable of full-time student status or self-support)? ❑ No ❑ Yes

If the diagnosis is mental retardation, please provide the mental age or I Q:_____

In your professional opinion do you consider the individual to be *temporarily incapacitated* and temporarily incapable of full-time student status and temporarily incapable of self-support? ❑ No ❑ Yes

If *Yes*, what date do you anticipate this individual will recover and be able to return as a full-time student or seek employment?_____

I hereby certify that all information provided in SECTION B above is correct to the best of my knowledge.

_____ _____ _____
Physician's Signature Date EIN/SSN

_____ _____
Print Physician's Name Physician's Telephone Number

Physician's Address:
_____
_____
_____
_____

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Please return this completed section to the subscriber who gave it to you.